PROVIDER REQUIREMENTS

A hospice provider must be Medicare-certified in order to qualify for enrollment as a Louisiana Medicaid hospice provider. The hospice provider must be enrolled prior to billing for any services provided to Medicaid beneficiaries.

Licensure

Except to the extent required by the licensing standards for hospice as defined in LAC 48:I.Chapter 82, §8205.A.1, it shall be unlawful to operate or maintain a hospice program without first obtaining a license from the Louisiana Department of Health (LDH). LDH is the only licensing authority for hospice providers in the state of Louisiana.

Provider Responsibilities

The hospice provider must ensure employees providing hospice services have all licensure, certification or registration requirements in accordance to applicable federal and/or state laws.

Inpatient Care Cap

A cap is placed on the number of allowable inpatient hospice days that can be provided by a hospice facility to fee-for-service beneficiaries during the twelve-month period beginning November 1st of each year to October 31st of the following year. This cap is calculated as twenty percent (20%) of the total number of hospice days provided by the facility.

A review of the total number of hospice days provided by a facility is performed annually. The rate for each day in excess of the allowable inpatient care cap is adjusted to pay the routine care amount. The difference between the two amounts shall be remitted to LDH.

Interdisciplinary Group

Additionally, the hospice provider must designate an interdisciplinary group (IDG) composed of qualified medical professionals and social support staff from all core services, with expertise in meeting the special needs of hospice beneficiaries and their families. The IDG must consist of the following individuals:

1. Physician;

2. Registered Nurse;

3. Social Worker; and

4. Pastoral or other counsel.

NOTE: Nurse practitioners (NPs) may not serve as medical director or as the physician member of the interdisciplinary group.

Plan of Care

A written plan of care (POC) must be established before services are provided and must be maintained for each beneficiary admitted to a hospice program in accordance with the provisions set forth in the Licensing Standards for Hospices (LAC 48:I.Chapter 82). The initial POC must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice. The date of the POC should be the date it is first established. The care provided to a beneficiary must be consistent with the plan and be reasonable and necessary for the palliation or management of the terminal illness as well as all related conditions. In establishing the initial POC, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member (nurse, physician, or medical social worker or counselor) before writing the initial POC. At least one of the persons involved in developing the initial POC must be a nurse or physician. The POC is signed by the attending physician or an appropriate member of the interdisciplinary group.

The POC must encompass plans on access to emergency care and address the condition of the beneficiary as a whole. All co-morbidities must be included even those not related to the terminal illness. In addition, the POC must meet general medical needs of beneficiaries to the extent that these needs are not being met by the attending physician. This information is being required to assess the beneficiary for complications and risk factors that would affect care planning (i.e., access to emergency care). Providers may not be responsible for providing care for the unrelated co-morbidities.

There is no official hospice POC form. Each hospice provider should develop a form which includes the required information and best meets its needs.

Physician Certification and Narrative

The hospice provider must obtain written certification of terminal illness via BHSF Form Hospice-CTI (Certification of Terminal Illness). The certification must specify that the beneficiary's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. The certification must be based on the physician's clinical judgment regarding the normal course

of the individual's illness and must include the signatures of the physicians. A copy of this certification must be on file in the beneficiary's clinical record.

Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with a written certification. In addition, the attending physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of six months or less. This may be done as an addendum to the certification and recertification forms if additional space is needed. The physician must also sign and date immediately following the narrative in the addendum. The physician must print and sign his/her name. The narrative must include a statement under the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the beneficiary's medical record or, if applicable, his or her examination of the patient. The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. Submit this narrative along with the signed CTI form to the Hospice PA Unit. A copy of this certification must also be on file in the beneficiary's clinical record.

The narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of six months or less.

Nurse Practitioners as Attending Physician

A nurse practitioner (NP) is defined as a registered nurse who is permitted to perform such services as legally authorized to perform (in the state in which the services are performed) in accordance with state law (or state regulatory mechanism provided by state law) and who meets training, education and experience requirements described in 42 CFR 410.75.

If a beneficiary does not have an attending physician or a NP who has provided primary care prior to or at the time of the terminal diagnosis, the beneficiary may choose to be served by either a physician or a nurse practitioner who is employed by the hospice provider. The beneficiary must be provided with a choice of a physician or a nurse practitioner. The attending physician or nurse practitioner must be identified on the NOE, or on an addendum to the NOE, during the election of hospice services. (See Section 24.2 – *Election of Hospice Care* of this manual chapter).

Services provided by a nurse practitioner that are medical in nature must be reasonable and necessary, be included in the POC and must be services that, in the absence of a nurse practitioner, would be performed by a physician. If the services performed by a nurse practitioner are such that a registered nurse could perform them in the absence of a physician, they are not considered

attending physician services and are not separately billable. Services that are duplicative of what the hospice nurse would provide are not separately billable.

Nurse practitioners cannot certify a terminal diagnosis or the prognosis of six months or less, if the illness or disease runs it normal course, or re-certify terminal diagnosis or prognosis. In the event that a beneficiary's attending physician is a nurse practitioner, the hospice medical director and another physician designee must certify or re-certify the terminal illness. When a NP performs the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of six months or less, should the illness run its normal course. Regulations require the narrative to be composed by the certifying physician only.

Certification of Terminal Illness

The hospice provider must obtain written certification of terminal illness (BHSF Form Hospice-CTI) for each of the election periods, even if a single election continues in effect for two or more periods. Written certifications may be completed two weeks before the beginning of each election period. See Appendix B for detailed information on completing the BHSF Form Hospice-CTI.

Certification of Initial Period

The hospice provider must obtain BHSF Form Hospice CTI no later than two calendar days after hospice care is initiated. If written certification is not obtained within two calendar days, verbal verification from the physician must be received by an interdisciplinary group (IDG) member and the verbal verification section on the form must be completed and submitted to BHSF within two calendar days following the initiation of hospice care. The clinical information may be provided verbally, and must be documented in the medical record and included as part of the hospice provider's eligibility assessment. Written certification must be obtained no later than eight calendar days after care is initiated. If the NOE (see Appendix A) physician's narrative and Certification of Terminal Illness Forms are not received within 10 calendar days of the initiation of hospice care, the date of admission (election) will be the date that BHSF receives the proper documentation.

NOTE: The 10 calendar day requirement is the same for Medicaid only beneficiaries as well as dual eligible (Medicaid/Medicare) beneficiaries.

Verbal Certification

If verbal certification is made, the referral from the physician must be received by a member of the hospice IDG. The entry of the verbal certification in the beneficiary's clinical record must include at a minimum the beneficiary's name, attending physician's name, terminal diagnosis, prognosis, and the name, date and signature of the IDG member taking the referral. The diagnosis code on the NOE and the diagnosis description on the CTI must match. The diagnosis description must be notated on the CTI.

Hospice staff must make an appropriate entry in the beneficiary's clinical record as soon as a verbal certification is received and file written certifications in the clinical record.

Sources of Certification

For the initial 90 calendar day period, the hospice provider must obtain a completed certification form from the following:

1. The beneficiary's attending physician. The attending physician must be a doctor of medicine or osteopathy and must be identified by the beneficiary, at the time of election for hospice care, as having the most significant role in the determination and delivery of the individual's medical care; and

2. The hospice's medical director or a physician member of the hospice IDG.

The beneficiary shall not be required to relinquish his/her attending physician in order to receive hospice benefits. If the attending physician wishes to relinquish care of the beneficiary to the hospice's medical director, the attending physician must:

1. Sign the BHSF Form Hospice-CTI; and

2. Submit a narrative statement indicating relinquishment of the care of the patient to the hospice physician.

For all subsequent periods, the hospice provider must submit the completed CTI form to the PA Unit within 10 calendar days prior to the last day of the current benefit period. The form must be signed and dated by either the medical director or a physician member of the IDG.

Face-to-Face Encounters

Section 3131(b) of the Affordable Care Act of 2010 requires a hospice physician or NP to have a face-to-face encounter with every hospice beneficiary to determine the continued eligibility of that beneficiary prior to the beneficiary's 180th day recertification and each subsequent recertification. These required encounters are due no more than 30 calendar days prior to the recertification date. LDH will align with the Centers for Medicare and Medicaid Services (CMS) regarding the face–to–face requirement.

The regulation requires that the hospice physician or NP attest that the encounter occurred, and the recertifying physician must include a narrative which describes how the clinical findings of the encounter support the beneficiary's terminal prognosis of six months or less. The attestation language must be located directly above the physician or NP attestation signature and date line. The physician or NP must sign and date the form. The statement must include the date of visit, the requested period, signature of the physician or NP who made the visit along with his date of signature. The physician must print and then sign his/her name. Visit notes are not a substitute for a physician narrative, which is a brief explanation of the clinical findings that supports continuing eligibility for the hospice benefit. Outside attending physicians are not allowed to perform the face-to-face encounter. The hospice provider is responsible for either providing the encounter itself or for arranging for the encounter. Please note volunteer physicians are considered hospice employees. Hospice providers are supposed to provide physician services to their beneficiaries when needed during a time of crisis.

If a beneficiary improves or stabilizes sufficiently over time while in hospice, such that he/she no longer has a prognosis of six months or less from the most recent recertification evaluation or definitive interim evaluation, that beneficiary should be considered for discharge from Medicaid hospice services.

NOTE: In the event that a beneficiary is in the hospital or emergency room, and a referral is made to hospice, the physician attending to the beneficiary in the hospital or emergency room or the physician referring the beneficiary to hospice services must sign the BHSF Form Hospice-CTI, if the beneficiary does not have an attending physician.

BHSF Written Notice of Hospice Decision

The Hospice PAU notifies the hospice provider and the hospice beneficiary (or legal representative) of the beneficiary's approval or denial of hospice services in writing. **It is the Hospice provider's responsibility to notify the nursing facility**. The approval letter contains the

election date and the prior authorization requirements (if applicable). The denial letter gives the reason(s) for the denial.

Disaster Operations

The provisions set forth in the Licensing Standards for Hospices (LAC 48:I. Chapter 82) state, "The hospice provider shall have policy and procedures and a written plan for emergency operations in case of disaster." To ensure compliance, all providers should adhere to the following procedure in the event a state emergency occurs where evacuations are required:

1. Transportation during an emergency evacuation of a nursing facility beneficiary receiving hospice services is the responsibility of the nursing facility;

2. Hospice beneficiaries who receive hospice services in their home and are without accessible transportation during an emergency evacuation will be directed to a parish pick-up point; and

3. Transportation during an emergency evacuation of an in-patient hospice facility beneficiary is the responsibility of the inpatient hospice facility.

It is the responsibility of the hospice provider to know the location of beneficiaries under their care at all times.

PROGRAM INTEGRITY

To maintain the programmatic and fiscal integrity of the Medicaid program, the federal and state governments have enacted laws, promulgated rules and regulations and policies concerning fraud and abuse, and LDH has established policies concerning those laws, rules, regulations and procedures. It is the responsibility of the provider to become familiar with these laws and regulations.

Non-compliance with the provider agreement may place the provider in a position of sanctions being imposed which include, but are not limited to, denial or revocation of enrollment, withholding of payments, exclusion from the program, recovery of overpayments and administrative fines.

Providers, beneficiaries and others may also be subject to criminal prosecution, civil action and/or administrative actions if they violate laws, rules, regulations or policies applicable to the Medicaid program.

Providers should refer to the *Medicaid Services Manual*, Chapter 1 *General Information and Administration* for a full description of administrative sanctions.

NOTE: The provider should also refer to the laws and regulations related to sanctions for each program of enrollment and should review the *Louisiana Administrative Code* (LAC), LAC 50:I. Chapters 41 and Subpart E.